WHITSETT VISION GROUP

Medical Records Department

Authorization to Use and Disclose Health Information

Patient Name:	Date of Birth:
Other Names Used:	Patient Email:

I authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

☐ Specific Date(s) of treatment:_____ ☐ All

Records will be used for:
☐ Continuing Medical Care ☐ Personal Use ☐ Legal Purposes ☐ Social Security/Disability

Records will be automatically produced securely, electronically, if not specified below.
Requesting paper copies will incur a fee of $25 for the first 20 pages and $0.50 per page thereafter.

I authorize Whitsett Vision Group to ***SEND*** records ***TO***:

____ Fax ____ Mail ____ Email

Recipient Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Email: _____

I authorize Whitsett Vision Group to ***RECEIVE*** records.

☐ **Memorial**: 1237 Campbell Rd, Houston, TX 77055
Fax: 713.365.9356

☐ **Katy East**: 23510 Kingsland Blvd, Ste 200, Katy, TX 77494
Fax: 281.395.7004

☐ **Katy West**: 23530 Kingsland Blvd, Ste 340, Katy, TX 77494
Fax: 832.437.0553 (Neuro-ophthalmology)

☐ **Spring**: 21848 Holzwarth Rd, Ste 200, Spring, TX 77388
Fax: 346.351.2818

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I would like this authorization to be in effect until: _____

I understand the information in my health records may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

__***Yes,*** I consent to the release of the above information. *[check one]* __***No,*** I do not consent to the release of the above information.

I understand my medical records may contain reports, test results and notes only a physician can interpret. I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent misunderstanding of the information contained in these entries. I will not hold Whitsett Vision Group liable for any misinterpretation of the information in my medical records as a result for not consulting my physician for the correct interpretation.

_____ _____
Patient/Legal Guardian Name (PRINT) **Relationship to Patient**

_____ _____
Patient/Legal Guardian Signature **Date**

_____ _____
Witness **Date**

In most cases, each medical records request will be reviewed, processed, and completed within 14 business days.